DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445272	A. BUILDING _____ B. WING _____	06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MABRY HEALTH CARE	1340 N GRUNDY QUARLES HWY P O BOX 7 GAINESBORO, TN 38562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED An annual Recertification survey and complaint investigation #29519 was completed on June 7, 2012, at Mabry Health Care and Rehab Center. No deficiencies were cited related to the complaint investigation under 42 CFR Part 483, Requirements for Long Term Facilities.	F 000	POC #3. Acceptable	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	F 156 Step 1. Post information regarding Medicaid benefits items and services available to residents and/or any charges due for services. Make copies available to anyone inquiring about possible admission to the facility. Additional documentation added to admission packet for review and completion upon admission (Resident Choices for Professional Services, Confidential Resident Financial Assessment, Management of Resident funds, Financial Agreement). Copies of all documents will be made available to resident and family members at the time of admission. Review information periodically with resident and/or family member during course of stay. The Medicare right to appeal notice is included in the documentation for review and completion. CMS form 10055 (Medicare Claim Appeal/Non-Coverage form) is now in place and being utilized.	7/3/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen M. Glass — TITLE: Adm — (X6) DATE: 7-7-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit, and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	F 156 (cont'd) Step 2. Resident #32,#62 and # 93 were not adversely affected by this documentation deletion. No other residents have been adversely affected due to the absence of these documentation. Step 3. Documentation will be available to any resident or family member concerning Medicaid qualifications. support systems are available to nursing home residents and appeal rights and notification Step 4. To ensure all informational documents are posted in the front office area and copies are available upon request. Additional documentation added to admission packet for review and completion upon admission	

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, the facility failed to provide three residents (#32, #82, #93) of three residents reviewed with an appropriate liability and appeal notice. The findings included: Review of facility documentation for three	F 156		

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F 156	Continued From page 3 residents #32, #62, and #83, revealed the Medicare denial letter did not include the notification of the beneficiary of his/her right to have a claim submitted to Medicare or advise of the standard claim appeal rights if the claim was denied by Medicare. Interview with the billing clerk on June 5, 2012, at 3:45 p.m., in the front office, confirmed the facility failed to provide the residents the appropriate liability and/or appeal notice. Interview with the Administrator on June 5, 2012, at 3:49 p.m., in the front office, confirmed the facility failed to provide the residents the appropriate liability and/or appeal notice.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to honor the dignity of one (#36) of thirty eight residents reviewed. The findings included: Resident #36 was admitted to the facility on May 7, 2012, with diagnoses including Diabetes Mellitus Type 2 uncontrolled, Hypertension, Hypokalemia, Chronic Pain Syndrome, Chronic	F 241	F 241 Step 1. The facility will promote each residents rights for dignity and respect of individuality. .) A.D.O.N. on 6/8/2012. 1) In-service all CNA and Nursing staff on rights and dignity 2) counseled CNA staff and nursing in proper use and monitoring of wash cloths during meals and snacks (To assure wash cloths are used prior to meals removing before meals are severed. After meal care with wash cloths available for cleansing to residents and removed promptly when soiled after meal. Resident #36 Upon documentation of nursing notes was interviewed and counseled by nursing staff and DON on proper use of wash cloths during meals at this time voiced understanding, but in regards to vision loss/blindness resident requires monitoring and assist with set of meals and hygiene care, staff aware of needs per care plan report.	7/6/2012

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F 241	Continued From page 4 Obstructive Pulmonary Disease, History of Lung Cancer, Thrombocytopenia, Depression, Anxiety, Dementia, Total Blindness, History of Pneumonia, Hyperkalemia, Acute Renal Failure, and History of Dehydration. Observation on June 4, 2012, at 11:15 a.m., in the D-wing dining room revealed resident #36 feeding self lunch. The resident picked up a washcloth that was covering the food and attempted to cut it with a butter knife, then attempted to bite/eat the washcloth. The resident finally gave up and put the washcloth down on the table. No staff intervened during the resident's attempt to eat the washcloth. Observation on June 6, 2012, at 11:20 a.m., revealed the resident sitting at the lunch table with a bowl of soup with the soup spilling onto the table. Continued observation revealed the resident attempted to use a spoon to eat the soup from the bowl, but the bowl was empty except for a washcloth. Continued observation revealed the resident attempted to bite and chew the washcloth, and no staff assisted or intervened. Interview on June 7, 2012, at 11:40 a.m., in the D-wing dining room with Certified Nurse Assistant #5 confirmed the resident occasionally will attempt to eat washcloths that are used to wash the hands, due to the resident's confusion and blindness. Interview on June 7, 2012, at 2:50 p.m., in the staff education room with the Administrator and the Director of Nursing confirmed the resident's dignity was not maintained when the resident was allowed to attempt to eat the washcloth.	F 241	STEP: 2 Date beginning 6-8-2012 Plan for continuation of care: DON and ADON will monitor residents by making rounds during meals in dinning areas 3 times weekly for 3 months to assure issues will be resolved and promptly address any issues that may occur with Nursing staff and resident. DON and ADON will pay frequent attention to resident #36 to assure issues are resolved. Step 3. On 6/25/2012 all staff in-serviced on resident care in dining room. In-service conducted by A.D.O.N. CNA #5 was counseled at the time of the incident by A.D.O.N. Step 4. Results of QA monitoring will be forwarded to QA committee for review and further recommendation.	

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to honor a request for one resident (#24) of thirty-eight residents reviewed. The findings included: Resident #24 was admitted to the facility on January 12, 2009, with diagnoses including Acute Respiratory Failure, Cerebrovascular Accident with Left Hemiplegia, Chronic Obstructive Pulmonary Disease (COPD), Anemia, Diabetes, and Right Hip Fracture. Medical record review of the Minimum Data Set dated April 17, 2012, revealed the resident was independent with daily decision making, was able to make needs known, required extensive assistance of one person for transfers, and did not walk. Medical record review of the Care Plan dated April18, 2012, revealed "...Resident had DX (diagnosis) of COPD...Encourage frequent rest periods..."	F 242	F 242 Step 1. 6-11-2012 Resident #24 Upon nursing documentation review DON and Social Service staff interviewed and informed resident #24 of self determination and the right to make choices at time of interview resident voiced understanding or care. CNA #2 and LPN #2 were counseled on resident rights by D.O.N. on 6/11/2012. Step 2. All staff in-serviced by D.O.N., A.D.O.N. on self determination and resident rights beginning 6/19/2012 and ending 7/3/2012. Step 3. D.O.N., A.D.O.N. to make rounds and monitor five residents weekly for three months beginning 6/25/2012. Residents will be interviewed regarding their rights to make choices. Upon admit/quarterly review of care plan MDS Coordinator will monitor and address of issues concerning resident rights of choice and address promptly with DON, ADON, SS for correction Step 4. Results of QA rounds will be forwarded to QA committee for review and further recommendation.	7/3/12

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F 242	Continued From page 6 Observation on June 4, 2012, at 2:35 p.m., revealed the resident sitting in a wheelchair in the resident's room with the call light turned on. Continued observation revealed Certified Nursing Assistant (CNA) #2 entered the resident's room and the resident stated was tired and requested to be transferred to the bed to lie down and rest. Continued observation revealed CNA #2 told the resident would ask the nurse if the resident could be transferred to the bed. Observation on June 4, 2012, at 2:40 p.m., revealed CNA #2 returned to the resident's room and told the resident, the nurse said the resident could not be returned to bed until after supper. Interview on June 4, 2012, at 2:37 p.m., with the resident, in the resident's room, revealed the resident had been assisted to the wheelchair at approximately 6:15 a.m., and had been in the wheelchair since, except for toileting.. Continued interview revealed the resident was tired and wanted to lie down on the bed. Interview on June 5, 2012, at 4:00 p.m., with Licensed Practical Nurse (LPN) #2, in the staff education room, confirmed LPN #2 had told CNA #2, on June 4, 2012, the resident was not to be transferred to bed until the supper meal was over.	F 242		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced	F 247		7/3/12

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F 247	Continued From page 7 by: Based on medical record review and interview, the facility failed to provide prior notification of a new room-mate assignment for one resident (#10) of thirty-eight residents reviewed. The findings included: Resident #10 was admitted to the facility on December 6, 2011, with diagnoses including Hypertension, Alzheimer's Type Dementia, and Depression. Medical record review of the re-admission Minimum Data Set assessment, dated February 21, 2012, revealed the resident was cognitively intact, scoring a fifteen of fifteeen on the Breif Interview for Mental Status. Medical record review of the Social Service notes and Nurses Notes for resident #10, revealed no documentation of prior notification to the resident prior to admitting another resident into the room on May 16, 2012. Interview with the resident on June 4, 2012, at 3:20 p.m. and on June 6, 2012, at 10:45 a.m., revealed the resident had resided in the same room since admission. Continued interview revealed on May 16, 2012, the facility admitted another resident into the room, without prior notification to resident #10 of the impending room-mate assignment. Interview with the front office staff, and the Director of Nursing, on June 6, 2012, at 3:40p.m., in the front office, revealed no documentation resident #10 received prior notification, written or	F 247	F 247 Step 1. Resident #10 was not adversely affected by the roommate change All residents and family members to be notified of any roommate and/or room changes in advance, before roommate is assigned Documentation by staff will be completed and put in resident chart by Admissions Coordinator. Admission Coordinator will address and document residents response to roommate and how the residents are adjusting to roommate 3-5 days after room change. Chart reviews/audits will be completed regarding room/roommate changes by D.O.N., A.D.O.N, approximately within 3-5 days after change has occurred on current and all future residents beginning 6/19/2012. Step 3. D.O.N. and A.D.O.N. will monitor staff for three months concerning roommate and/or room changes to insure documentation is done by chart review/audits. Form to be completed regarding resident and family being notified of room/roommate change by Social Services and accompanying documentation in chart. Step 4. Results of monitoring will be forwarded to QA committee for review and further recommendation.	7/6/2012

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F 247	Continued From page 8 verbal, of the new admission to the resident's room.	F 247		
F 251 SS=D	483.15(g)(2)&(3) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on review of facility personnel record, and interview, the facility failed to employ a qualified social worker. The findings included: Review of s social service personnel record revealed the Social Service Director did not have the qualifications of a Social Worker. Interview with the Social Service Director on June 5, 2012, at 3:53 p.m., in the front office, revealed the Social Worker had not completed a bachelor's degree in Social Work or a bachelor's degree in a Human Services field. Interview with the Administrator on June 7, 2012, at 3:00 p.m., in the staff education room revealed	F 251	F 251 Step 1. Previous licensed Social Worker was dismissed in December 2011. Beginning in December 2011, notices have been sent to (2) local newspapers and career centers for licensed Social Worker applications. Step 2 No resident was affected in the absence of licensed Social Worker. Resident's needs and concerns handled appropriately by stff Step 3 Make sure the facility has a full time licensed Social Worker. Step 4 Ensure licensed Social Worker is at the facility to meet regulations	6/21/12

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F 251	Continued From page 9 the facility failed to employee a qualified Social Worker.	F 251		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was functional and to safely lift one resident (#9), failed to ensure a safety device was in place for one resident (#67), and failed to safely transfer one resident (#12) of thirty-eight residents reviewed. The findings included: Resident #9 was admitted to the facility on January 14, 2007, with diagnoses including Syncope and Collapse, History of Osteoarthritis, Hypertensive Cardiovascular Disease, and Diabetes. Medical record review of the Minimum Data Set (MDS) dated April 14, 2012, revealed the resident had severely impaired cognitive skills, required limited assist of one person with transfers, required extensive assistance of two persons with walking, and had no falls since the prior	F 323	F 323 Step 1. Resident #9 and #12 were assessed by nursing and were not found to be adversely affected due to CNA's lifting resident by placing their arms under resident's axilla. CNA #6 and #7 in-serviced by D.O.N on 6/11/2012 in transferring techniques and use of gait belt. Resident #67 was assessed by nursing and was not found to be adversely affected due to body alarm not connected to resident. Resident #9 was assessed by nursing and was affected by body alarm not secured to wheelchair. Body alarms assessed for correct placement and proper function by D.O.N. on 6/11/2012. All staff counseled by A.D.O.N. and P.T.A. on 6/25/2012 for proper transferring techniques and use of gait belt and proper use of safety devices.	7/6/2012

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F 323	Continued From page 10 assessment. Medical record review of the Fall Risk Assessment dated April 2, 2012, revealed the resident was at high risk for falls. Medical record review of the Care Plan dated April 18, 2012, revealed "...Resident has history of falls...Body alarm when up in chair Observation on June 6, 2012, at 3:26 p.m., with the Director of Nursing (DON), revealed the resident sitting in a wheelchair with a body alarm clipped to the left shoulder, and the base of the alarm was attached to the back of the wheelchair. Medical record review of a nursing note dated June 4, 2012, at 8:00 p.m., revealed "Called to room per residents roommate. Resident sitting in floor on buttocks facing the bed with bilat (bilateral) arms @ (at) sides et (and) legs stretched outward in front of person under the bed. w/c (wheelchair) @ bedside. Alarm attached to resident clothing but did not sound. Alarm string did not detach from base. Base not properly secured to w/c...skin tear noted to anterior aspect LLE (left lower extremity) approx 3.5cm (centimeters)..." Telephone interview on June 7, 2012, at 8:45 a.m., with Licensed Practical Nurse (LPN) #3 confirmed when the resident fell on June 4, 2012, the base of the alarm was not attached to the wheelchair, and therefore did not sound. Observation on June 7, 2012, at 10:05 a.m., revealed resident #9 seated on a chair to be weighed in the shower room. Continued	F 323	F 323 (cont'd) Step 2. Licensed and certified staffing serviced on thee use of gait belt and transferring techniques beginning 6/19/2012 by D.O.N., A.D.O.N. All licensed and certified staff in-serviced on proper use of and applying of safety devices beginning 6/19/2012 to be completed by 7/3/2012 with ongoing education to be provided as needed by D.O.N., A.D.O.N., and P.T.A. Step 3. D.O.N., A.D.O.N., MDS Nurse will make rounds three times weekly for three months to monitor use of gait belt for transferring and for proper use of and applying safety devices starting on 6/25/2012 Therapy staff will complete screen of residents with each Admit, Quarterly and SCS assessment to review residents that may be at risk to assure proper gait transfers are being utilized by staff and to instruct new transfers techniques if needed evidence by documentation of fimctional plan log. for each scheduled resident Step 4. Results of QA monitoring will be forwarded to QA committee for review and further recommendation.	

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	445272	A. BUILDING _____ B. WING _____	06/07/2012

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F 323	Continued From page 11 observation revealed the resident's feet did not touch the floor. Continued observation revealed the DON and a Certified Nursing Assistant placed their arms under the resident's axilla area and lifted the resident to the back of the chair. Interview on June 7, 2012, at 10:55 a.m., with the DON, in the Staff Education Office, revealed a gait belt was to be used when lifting or transferring residents, and confirmed resident #9 was not lifted safely when repositioned to the back of the chair in the shower room. Resident #67 was admitted to the facility on May 21, 2012, with diagnoses including Weakness, Decline in Activities of Daily Living, and Difficulty in Walking. Medical record review of the MDS dated May 28, 2012, revealed the resident had severely impaired cognitive skills, required limited assistance of one person with transfers, required extensive assistance of two persons with walking, and had no falls since prior assessment. Medical record review of the Fall Risk Assessment dated May 22, 2012, revealed the resident was at high risk for falls. Medical record review of the Care Plan updated June 3, 2012, revealed "...body alarm when up in wheelchair..." Observation on June 6, 2012, at 11:02 a.m., in the dining room, with the DON, revealed the resident in the wheelchair with the body alarm not connected to the resident. Interview at this time,	F 323		

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F 323	Continued From page 12 with the DON, confirmed the body alarm was not attached to the resident. Resident #12 was admitted to the facility on January 21, 2012, with diagnoses including Dementia, Alzheimer's Disease, and Depression. Medical record review of the MDS dated April 30, 2012, revealed the resident had severely impaired cognitive skills, totally dependent of two persons for transfers, did not ambulate, and had no falls since prior assessment. Observation on June 6, 2012, at 12:53 p.m., in the D-hall spa room, revealed resident #12 seated in a geri-chair to be toileted in the spa room. Continued observation revealed Certified Nurse Aide (CNA) #6 and #7 placed their arms under the resident's axilla area lifted and transferred the resident to the shower chair. Further observation after toileting revealed CNA #6 and #7 placed their arms under the axilla area, lifted the resident, and transferred the resident back to the geri-chair. Interview on June 7, 2012, at 10:55 a.m., with the DON, in the Staff Education Office, revealed a gait belt was to be used when lifting or transferring residents, and confirmed resident #12 was not lifted safely.	F 323		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 354		7/3/12

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F 354	Continued From page 13 Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and interview, the facility failed to employ a full time registered nurse in the role of Director of Nursing as required. The findings included: Observation and interview during the survey entrance conference on June 4, 2012, at 9:20 a.m., in the staff education room with Licensed Practical Nurse (LPN #4) and the Administrator revealed LPN #4 was introduced as the Director of Nursing (DON) for the facility. Review of documents provided by the facility, on June 4, 2012, revealed the List of Key Personnel, dated January 9, 2012, identified LPN #4 as the DON. Continued documentation review revealed a notice, on company letterhead, dated October 14, 2011, stating "(LPN #4) will be Mabry Health Care's acting Director of Nursing." Interview with the Administrator and LPN #4, on June 7, 2012, at 2:35 p.m., in the staff development room, confirmed there was no waiver related to Nursing Services for the facility.	F 354	F 354 Step 1. An RN in place as D.O.N. effective 6/7/2012. Step 2. In the absence of a RN as D.O.N., resident's needs and concerns were handled by nursing staff and facility Administrator. RN staff monitored handling of resident care and concerns. Step 3. Administrator will monitor and make sure the facility has a full time RN designated as D.O.N. Step 4. Administrator will keep QA committee informed and involved regarding RN as D.O.N. at facility full time to meet regulations.	

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F 354	Continued From page 14 Continued interview confirmed LPN #4 had been acting in the DON role since October 14, 2011, and a full time Registered Nurse was not employed for that position as required.	F 354		
F 361 SS=F	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to provide a qualified dietician or a Director of Food Services on a full time basis. The findings included: Interview on June 6, 2012, at 3:30 p.m., at the A/B nurse's station with the Registered Dietician (RD) revealed the RD worked three days a week and no Dietary Manager was employed by the facility on a full time basis.	F 361	F 361 Step 1. R.D. employed with this facility for six or seven years has been on leave for six weeks. The R.D. will return in July 2012. The facility Administrator will assist with any dietary concerns that arise. Step 2. No resident was affected in the absence of R.D. The facility Administrator took care of all dietary concerns. Step 3. The facility Administrator will monitor for appropriate staff. The facility Administrator will make sure the facility has a full-time R.D. or dietary manager with consulting R.D. Step 4. Facility Administrator will ensure R.D. and/or dietary manager are at the facility to meet regulations. Administrator will keep QA committee informed of all dietary concerns.	7/3/12

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F 361	Continued From page 15 Interview on June 7, 2012, at 2:30 p.m., in the student education room with the Administrator confirmed the facility employed the RD for three days a week and the facility did not employ a full time Dietary Manager or Director of Food Services.	F 361		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F 441 Step 1. LPN #2 has been re-educated on hand washing policy. No residents were found to be adversely affected by nurse not following had washing policy. LPN #5 was re-educated on glove policy. No residents was found to be adversely affected by nurse not following policy. Step 2. Licensed and certified staff in-serviced on infection control policy beginning 6/25/2012 by D.O.N., Step 3. D.O.N., A.D.O.N., MDS Nurse will monitor staff during medication pass three times weekly for three months for proper hand washing and glove usage Step 4. Results of QA monitoring will be forwarded to QA committee for review and further recommendation. 7/6/2012	7/3/12

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F 441	Continued From page 16 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to maintain infection control during med pass for one resident (#57), and failed to apply gloves prior to administering an insulin injection for one resident (#70) of thirty-eight residents reviewed. The findings included: Observation on June 5, 2012, at 11:40 a.m., on the A/B Hall, revealed Licensed Practical Nurse (LPN) #2 passing medications. Continued observation revealed LPN #2 exited resident #67's room after administering medications, prepared resident #57's medications, and administered the medications without washing the hands. Review of facility policy, Hand Washing, no date, revealed "...wash hands before and after caring for each resident..." Interview on June 5, 2012, at 11:45 a.m., with LPN #2, in the A/B hall, revealed hands should be washed or sanitized between resident contact and confirmed the hands were not washed or sanitized between administering medications to the residents.	F 441		

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F 441	Continued From page 17 Observation on June 7, 2012, at 7:30 a.m., revealed LPN #5 administered an insulin injection to resident #70 with ungloved hands. Review of the Gloves Policy, no date, revealed "...use disposable gloves when there is potential exposure to blood..." Interview on June 7, 2012, at 7:30 a.m., with LPN #5, at the time of the observation, revealed gloves were to be worn when there is potential contact with blood or body fluids, and confirmed gloves were not worn when the insulin injection was administered to the resident.	F 441		
F 461 SS=F	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS-- WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations--	F 461		7/3/12

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F 461	Continued From page 18 (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide closet space accessible to one resident (#35) of thirty-eight residents reviewed. The findings included: Resident #35 was admitted to the facility on October 28, 2008, with diagnoses including Scoliosis, Lumbar Strain, and Ortho Hypotension. Observation on June 6, 2012, at 4:20 p.m., in the resident's room, revealed the resident in a wheelchair attempting to access the closet designated for the resident. Continued observation revealed the resident's roommate's bed was positioned in front of the closet door, and the resident was unable to open the closet door. Observation on June 7, 2012, at 11:00a.m., in the resident's room, revealed the resident in a wheelchair and the roommate's bed was positioned in front of the closet door. Interview with the resident, at this time, confirmed the resident is unable to access the closet and would like to access personal belongings. Interview with the Nursing Home Administrator on June 7, 2012, at 9:10 a.m., in the resident's room,	F 461	F 461 Step 1. Resident #35 was not able to access her designated closet in her wheelchair. Admissions Coordinator and A.D.O.N. went and spoke with resident regarding room location. The only way to insure the resident is able to access closet in wheelchair; she would need to move to another hall in the facility. Resident informed staff that she did not want to move from her present room. This resident's choice to remain in her present room is documented with her signature in her chart. This resident is satisfied with facility staff assisting her. Resident is still making her own choices regarding her clothing, she is only being assisted by staff. The room this resident occupies is configured for two person occupancy.	

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F 461	Continued From page 19 confirmed the facility failed to provide the resident accessible closet space.	F 461	F461 (cont'd) Step 2. Resident #35 is not adversely affected by her inability to access her closet. She prefers to have the staff assist with access to clothing.	7/6/2012
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, the facility failed to ensure a Physician designated by the facility attended and participated in the facility's Quality Assessment and Assurance (QA) Committee.	F 520	Step 3. Facility staff will discuss room assignment with resident and/or family member to be sure resident is satisfied with room and amenities. Step 4. Results will be forwarded to QA committee for review and further recommendation.	

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F 520	Continued From page 20 The findings included: Review of sign in sheets for the quarterly Quality Assessment and Assurance Committee meetings dated June 2011 through May 2012, revealed the Physician failed to attend the meetings. Interview with the Medical Director by telephone on June 6, 2012, at 3:30 p.m., confirmed the Physician does not attend or participate in the QA meetings. Interview with the Director of Nursing on June 7, 2012, at 1:30 p.m., in the staff education room, confirmed a Physician did not attend or participate in the Quality Assessment and Assurance program.	F 520	F 520 Step 1. Physician/Medical Director for facility will attend and participate in the facility's quality assessment and assurance committee Step 2. D.O.N., A.D.O.N to conduct quarterly QA meeting. QA committee will consist of (Medical Director), (Administrator), (D.O.N.), (A.D.O.N.), (Registered Dietician), (Admissions Coordinator), (Acting Social Worker), (MDS Coordinator) Step 3. D.O.N., A.D.O.N. will monitor QA meetings and ensure designated staff members attend quarterly meetings. Step 4. Results will be forwarded to QA committee for review and further recommendation.	6/7/12